King County
Work & Life Benefits

Medical Plan Summaries
KingCare Basic and KingCare Preferred Plans

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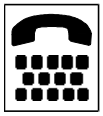
Final (revised)
January 4, 1999

Directory

If you have questions about ...	Contact ...
• Benefits eligibility • Enrollment • When coverage begins • Other King County Work & Life Benefits	**Benefits & Well-Being** at 206-684-1556 (8:30 a.m. – 4:30 p.m. Monday – Friday, except 10:30 a.m. – 4:30 p.m. Thursday) www.metrokc.gov/ohrm/benefits Exchange Building Mail Stop EXC-HR-1030 821 Second Avenue Seattle WA 98104-1598
• Providers (physicians, hospitals, etc.) • Filing claims • Other plan details (covered expenses, limitations, exclusions, out-of-area coverage, specific medical conditions or treatment, etc.)	**KingCare (Ethix)** at 1-800-654-3250 ext. 77020 (8 a.m. – 5 p.m. Monday – Friday) www.kingcare.com PO Box 91023 Seattle WA 98111-9123
• Preauthorization for certain care (see "Obtaining Preauthorization" for details)	**KingCare (Ethix)** at 1-800-654-7714
• Preauthorization for mental health or chemical dependency treatment	**King County's Making Life Easier Program** at 1-888-874-7290 (24 hours a day, 7 days a week)
• Your health or health care services	**KingCare (Ethix) Personal Health Advisor** at 1-800-520-1764 (24 hours a day, 7 days a week)

The information in this booklet is available in accessible formats by calling Benefits and Well-Being at 206-684-1556 (voice) or through Washington State Telecommunication Relay Service at 1-800-833-6388.



Although this booklet includes certain key features and brief summaries of this medical coverage, it does not provide detailed descriptions. If you have specific questions, contact Ethix or Benefits and Well-Being.

We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and legal documents, the legal documents will always govern.

King County intends to continue these plans indefinitely but reserves the right to amend or terminate them at any time, in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents.

This booklet does not create a contract of employment with King County.

Learn More About … *On Page …*

Learn More About (cont'd) … On Page …

Highlights

Here are a few highlights of your coverage under the KingCare Basic and KingCare Preferred Plans:

- You pay an annual deductible before the plans pay benefits (except for prescription drugs, preventive care and hearing aids).
- You do not pay a copay for office visits.
- The KingCare Basic Plan offers 2 levels of benefits: network benefits (generally paid at 80%) and non-network benefits (generally paid at 60%). You have the choice between these levels of benefits each time you need care.
- The KingCare Preferred Plan also offers 2 levels of benefits: network benefits (generally paid at 90%) and non-network benefits (generally paid at 70%). You have the choice between these levels of benefits each time you need care.

Important Facts

This booklet describes the KingCare medical plans. However, there are many important topics including laws, regulations and county provisions that affect more than just these plans. These provisions can change frequently. To be more efficient, and avoid repetition, we included the following topics in your "Important Facts" booklet:

- What Happens If (you take a leave of absence, become disabled, etc.)
- Eligibility
- Enrolling in the Plans
- When Coverage Begins
- Qualified Medical Child Support Order (QMCSO)
- When Coverage Ends
- Continuation of Coverage (COBRA)
- Assignment of Benefits
- Third Party Claims
- Recovery of Overpayments
- Termination and Amendment of the Plans
- Medical Plan Participant Bill of Rights.

Who's Eligible

Refer to your "Important Facts" booklet for information about eligibility and appeal of eligibility.

Cost

When you receive medical care, you pay:

- An annual deductible
- Required copays for emergency room care or prescription drugs, paid at the time of the service
- Coinsurance amounts not covered by the plans
- Amounts in excess of the usual, customary and reasonable (UCR) charge (see page 33 for a definition)
- Expenses for services or supplies not covered by the plans.

See "Medical Plan Summary" on page 3 for more information on deductibles, copays and coinsurance amounts. See your enrollment materials for information related to any monthly cost of coverage.

Enrolling in the Plans

If you are a newly hired employee, you must submit a completed enrollment form to Benefits and Well-Being within 30 days of your hire date; otherwise, you will receive default coverage. See your enrollment materials for details.

Making Changes

Each year during open enrollment, you may change your elections. Under certain circumstances, you may make changes during the year. Refer to your "Important Facts" booklet for information.

When Coverage Begins

Refer to your "Important Facts" booklet for information on when coverage begins.

Preexisting Condition Limit

These plans do not have a preexisting condition limit. However, there is a waiting period for transplants, see page 20 for more information. If you end employment with King County, please refer to the "Certificate of Coverage" section on page 28 for information on how your participation in these plans could be credited against another plan with a preexisting condition limit.

How the KingCare Plans Work

Medical Plan Summary

The following table summarizes covered services and supplies under these KingCare plans and identifies related coinsurance, copays, maximums and limitations. Please refer to "Covered Expenses" and "Expenses Not Covered" for more information on your medical benefits. Only medically necessary services and supplies are covered.

	KingCare Basic		KingCare Preferred		For more information refer to …
	Network	Non-Network❶	Network	Non-Network❶	
Annual deductible❷	$250/person $750/family		$50/person $150/family		Page 5
Lifetime maximum	$2,000,000				Page 6
Covered Expenses	**Plans Pay**				
Alternative care (certain specific services)	80%	60%	90%	70%	Page 9
Ambulance services	80%	80%	90%	90%	Page 10
Chemical dependency treatment (up to $10,000 in plan payments in 24 consecutive months) ❸	80%	60%	100%	70%	Page 10
Chiropractic care (up to 33 visits/year) ❸	80%	60%	90%	70%	Page 10
Circumcision	80%	60%	90%	70%	—-
Diabetes care training	80%	60%	90%	70%	Page 10
Durable medical equipment and prosthetics	80%	80%	80%	80%	Page 10
Emergency care (in an emergency room; $50 copay; waived if directly admitted)					Page 11
- Emergency care	80%	80%	90%	90%	
- Nonemergency care	80%	60%	90%	70%	
Family planning	80%	60%	90%	70%	Page 11
Growth hormones (subject to approval)	80%	60%	90%	70%	Page 12
Hearing aids (up to $500/3-year period) deductible doesn't apply❸	100%	100%	100%	100%	Page 12
Home health care (up to 130 visits/year) ❸	100%	100%	100%	100%	Page 12
Hospice (6 months lifetime hospice maximum; 120 hour maximum for respite care in any 3-month period) ❸	100%	100%	100%	100%	Page 12
Hospital care - inpatient and outpatient (inpatient subject to preauthorization) ❹	80%	60%	90%	70%	Page 13
Infertility (up to $25,000 lifetime maximum) ❸	80%	60%	90%	70%	Page 14

❶ Payments for covered non-network services are based on UCR amounts.
❷ Covered expenses applied to the deductible during the last 3 months of the plan year also may be applied to the next year's deductible.
❸ The maximum applies to all network and non-network care combined.
❹ If the same hospitalization continues from one year into the next, a second deductible will not be required for any treatment before discharge. Additional coinsurance also will not be required for any treatment before discharge if you've met the out-of-pocket maximum for the year the hospitalization began.

Medical Plan Summary (cont'd)

Covered Expenses	KingCare Basic		KingCare Preferred		For more information refer to …
	Network	Non-Network❶	Network	Non-Network❶	
Injury to teeth (up to $600/accident) ❸	80%	60%	90%	70%	Page 14
Inpatient care alternatives	80%	60%	90%	70%	Page 14
Lab, x-ray and other diagnostic testing	80%	60%	90%	70%	Page 14
Maternity care	80%	60%	90%	70%	Page 14
Mental health care					Page 15
- Inpatient (30-days/year) ❸	80%	60%	90%	70%	
- Outpatient (52 visits/year) ❸ (when deemed appropriate; unused visits may be traded for unused inpatient days)	50%	50%	50%	50%	
Neurodevelopmental therapy ($2,000 annual benefit maximum) ❸	80%	60%	90%	70%	Page 16
Physician and other medical and surgical services	80%	60%	90%	70%	Page 16
PKU formula	80%	60%	90%	70%	Page 16
Prescription drugs (no deductible)					Page 16
- Network pharmacy (up to 30-day supply)	100% after $5 copay/ generic; $10 copay/ brand-name prescription	Not covered	100% after $5 copay/ generic; $10 copay/ brand-name prescription	Not covered	
- Mail order (up to 100-day supply)	100% after $10 copay/ prescription	Not covered	100% after $10 copay/ prescription	Not covered	
Preventive care (no deductible)	100%	60%	100%	70%	Page 18
Radiation therapy, chemotherapy and respiratory therapy	80%	60%	90%	70%	Page 18
Reconstructive services	80%	60%	90%	70%	Page 18
Rehabilitative services (inpatient and outpatient)	80%	60%	90%	70%	Page 19
Skilled nursing facility	80%	60%	90%	70%	Page 19
Smoking cessation ($500 lifetime benefit maximum) ❸	80%	60%	90%	70%	Page 20
TMJ (up to $2,000/calendar year) ❸	80%	60%	90%	70%	Page 20
Transplants (certain services only)	100%	60%	100%	70%	Page 20
Urgent care	80%	60%	90%	70%	Page 21

❶ Payments for covered non-network services are based on UCR amounts.
❸ The maximum applies to all network and non-network care combined.

How the Plans Pay Benefits

The following chart shows how benefits are determined for most covered expenses.

Plan Feature	KingCare Basic Plan	KingCare Preferred Plan
You pay the annual deductible.	$250/person $750/family	$50/person $150/family
You pay copays if you need prescription drugs or emergency room care.	See "Medical Plan Summary" for amounts	See "Medical Plan Summary" for amounts
After the deductible/copays, the plans pay most covered services at this level ...	80% network; 60% non-network	90% network; 70% non-network
Until you reach your annual out-of-pocket maximum…	$800 network; $1,600 non-network	$400 network; $1,200 non-network
Then, most benefits are paid for the rest of the year at …	100%*	100%*

* Network and non-network expenses combined.

Annual Deductible

Before you receive plan benefits, you must meet the annual deductible listed on page 3.

If 3 or more family members together incur $750 in covered expenses for the KingCare Basic Plan, or $150 in covered expenses for the Preferred Plan, you meet the family deductible. This means no further deductible will be required from any family member for the rest of that year.

If you and your family members are in the same accident, only 1 deductible will apply.

Annual Out-of-Pocket Maximum

The out-of-pocket maximum is the most you pay in coinsurance for covered expenses each plan year. This means once you reach your out-of-pocket maximum, the plan pays 100% for most covered expenses for the rest of that year. If you have 3 or more family members (including yourself), each family member's covered expenses accumulate toward the family out-of-pocket maximum.

Annual Out-of-Pocket Maximum (cont'd)

The amount of your out-of-pocket maximum depends on whether you receive network care, non-network care or a combination. Here's how it works:

During the entire plan year, if you receive …	Your out-of-pocket maximum is …	
	KingCare Basic Plan	**KingCare Preferred Plan**
Network care only	$800/person $1,600/family	$400/person $800/family
Non-network care only	$1,600/person $3,200/family	$1,200/person $2,400/family
Combination of network and non-network care	20% of covered network expenses plus 40% of covered non-network expenses	10% of covered network expenses plus 30% of covered non-network expenses
	These percentages apply to a combined maximum of $4,000 in covered network and non-network expenses/individual or $8,000/family.	

The following do not apply to the out-of-pocket maximum:

- Annual deductible
- Copay amounts
- Coinsurance for smoking cessation programs and mental health care
- Amounts in excess of UCR
- Charges beyond benefit maximums
- Expenses not covered under the plans.

Lifetime Maximum

The total amount paid for all benefits from the KingCare Basic Plan *and* KingCare Preferred Plan is limited to a lifetime maximum of $2,000,000. Up to $20,000 of this maximum is restored automatically at the start of each plan year for benefits paid during the prior year. Some expenses are also subject to annual or lifetime benefit limits; see "Medical Plan Summary" starting on page 3.

The Network

To be considered for the network all hospitals must be accredited by the Joint Commission on Accreditation of Health Care Organizations and have a current state license as well as adequate liability insurance. Doctors or other health care professionals must also meet credentialing requirements to be considered for the network. The credentialing process requires completion of a detailed application, including education, status of board certification, malpractice and state sanction histories.

All providers — hospitals, clinics, doctors and other health care professionals who make up the network — are carefully screened by Ethix. Ethix is solely responsible for determining which providers participate in the network.

Accessing Care

You may take advantage of either network benefits or non-network benefits; the level of coverage you receive depends on the provider you see.

To receive network benefits:

- You choose a network provider from the provider directory and make an appointment
- Your network provider must obtain preauthorization for your care as necessary (see the next section for details)
- You meet the annual deductible and pay any required copays or coinsurance
- The plan pays benefits and handles most forms and paperwork
- You receive a bill from your network provider for your share of the cost (or "coinsurance").

To receive non-network benefits:

- You make an appointment with a non-network provider
- You must obtain preauthorization for certain procedures and services as described below
- You meet the annual deductible, and pay any required copay or coinsurance
- The plan pays benefits
- You pay the bill in full and file a claim for reimbursement
- You are responsible for any charges that exceed the UCR amounts.

Second Opinions

On occasion, you may want a second opinion. To receive network benefits, you must get a second opinion from a network provider. At any point, you may decide to see a non-network provider and receive non-network benefits.

Obtaining Preauthorization

If you see a network provider, he or she will obtain preauthorization for your care when necessary.

If you see a non-network provider, you are responsible for obtaining preauthorization for certain services or supplies. This means you must call or ask your physician to call and obtain preauthorization on your behalf.

You may then call Ethix at 1-800-654-7714 to check that your physician followed through. The following sections outline when to call, how to call and what happens if you don't obtain preauthorization.

If you obtain preauthorization, benefits will be paid according to plan provisions and limitations. It's possible benefits would not be paid if, for example, you aren't eligible for coverage on the day you receive the care.

Ethix will confirm the preauthorization in writing. It will be valid for 3 months, if your condition does not change.

When to Call: If you see a non-network provider, you must obtain preauthorization for these covered services:

- Anorexiants for treatment of attention deficit disorder or narcolepsy
- Durable medical equipment
- Home health care
- Hospice care
- Hospitalizations (other than for most stays in connection with childbirth)

Obtaining Preauthorization (cont'd)

- Injectable prescription drugs except for insulin and Depo-Provera
- Inpatient chemical dependency treatment
- Inpatient mental health care
- Skilled nursing facility care
- Transplants.

If you are having surgery or being admitted to a hospital (except for childbirth), Ethix must be notified *at least 7 days* before the surgery or admission. Before admission, be sure to confirm with the hospital that your stay has been preauthorized.

You must call Ethix within 48 hours from the start of your care — or as soon as reasonably possible — for:

- Accidents (see page 30 for a definition)
- Emergencies (including detoxification)
- Maternity admissions
- Involuntary commitment to a Washington state mental hospital.

How to Call: To obtain preauthorization for your nonemergency care (or authorization after your emergency care), have your physician call Ethix at 1-800-654-7714
Monday - Friday, 8:00 a.m. to 5:00 p.m.

For chemical dependency treatment or mental health care: You also may call King County's Making Life Easier Program at 1-888-874-7290. Staff will obtain preauthorization as necessary and refer you to a provider for treatment.

When calling, be prepared to provide the following information:

- Employee's name and Social Security number
- Patient name, address, date of birth
- Employer name
- Physician name and address or phone number
- Hospital name and address or phone number
- Admission date
- Diagnosis or surgery
- Proposed treatment plan, including length of stay and discharge planning needs.

If You Don't Obtain Preauthorization: If your care is not preauthorized as described above — and Ethix determines your care was not medically necessary — the charges for your care may be only partially paid or may not be paid at all.

Medical Case Management

When determined to be medically necessary as well as care and cost effective, these plans may offer or approve alternative benefits on a case-by-case basis. Alternative benefits will only be approved when traditional benefits would otherwise be available under these plans.

Example: When provided at equal or lesser cost, benefits could be available for home health care—instead of hospitalization or other institutional care—when provided by a licensed home health, hospice, or home care agency.

Less expensive or less intensive services will only be approved for alternative benefits with your consent and when your physician confirms the services are adequate. A written treatment plan may be required and approved by the provider.

The decision to offer or approve alternative benefits remains with these plans and will be determined based upon individual medical needs. The amount of coverage for approved alternative benefits will not exceed the amount that would otherwise be available for approved traditional benefits.

Managing Your Health

Personal Health Advisor: To help you make more informed health care decisions, these plans offer health care information, support and referral services from a Personal Health Advisor (call 1-800-520-1764 for details):

- Clinical assessment/triage
- Health events counseling
- Medication counseling
- Complementary and home treatment options
- Help in choosing providers and managing costs
- Referral services.

Personal Health Risk Assessment Profile: When joining the plan for the first time, employees can complete a confidential health risk assessment and receive a personal profile to obtain important advice on reducing risk factors associated with poor health (such as diet, stress and smoking).

Call Ethix at 1-800-654-3250 to request a health risk assessment.

Covered Expenses

To be covered, services and supplies must be considered medically necessary by these plans. See definition on page 32. The following section describes expenses covered by both the KingCare Basic and KingCare Preferred Plans. For information on the level of benefits you receive (for example, related coinsurance, copays, maximums and limitations), refer to "Medical Plan Summary" on page 3. Also see "Expenses Not Covered" on page 21.

If you see a non-network provider, you must obtain preauthorization for certain services and supplies. See "Obtaining Preauthorization" on page 7 for details.

Referrals are not required for any of the following benefits under these plans.

Alternative Care

Covered services include:

- Acupuncture, limited to services for chronic pain symptoms
- Hypnotherapy for chronic pain control or services prescribed by a covered mental health provider specified in the mental health care benefit section
- Massage therapy prescribed by a physician and designed to restore and improve physical functioning lost due to a covered illness or injury (covered under the rehabilitative or neurodevelopmental benefit)

Alternative Care (cont'd)

- Naturopathy, limited to physical exams, diagnosis, interpretation of laboratory tests, nutritional counseling for chronic diseases in which dietary adjustment has a therapeutic role, and treatment of chronic conditions.

After 20 visits per diagnosis for any of the alternative care listed above, your medical records will be requested to determine the medical necessity of further treatment.

The plans do not cover nutritional counseling for:

- Obesity or weight loss unless you have a coexisting condition that is obesity-related
- Conditions which have not been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and hyperactivity.

Ambulance Services

These plans cover medically necessary emergency ground or air ambulance services to a network facility or the nearest facility where appropriate care is covered.

Chemical Dependency Treatment

Inpatient and outpatient chemical dependency treatment is covered, including:

- Covered prescription drugs and medicines
- Detoxification services
- Diagnostic evaluation and education
- Organized individual and group counseling.

Chemical dependency benefits are payable up to $10,000 (in plan payments) in 24 consecutive months. Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for inpatient chemical dependency treatment.

For additional counseling and referral services, you may also call the King County's Making Life Easier Program at 1-888-874-7290.

Chiropractic Care

The plans cover services of licensed chiropractors, up to 33 visit per year, limited to diagnosis and treatment of musculoskeletal disorders, including:

- Diagnostic laboratory services directly related to the spinal care treatment you are receiving
- Full spinal x-rays
- Non-invasive spinal manipulations.

The plans do not cover spinal manipulations under anesthesia.

Diabetes Care Training

The plans cover diabetic care training when prescribed by your physician.

Durable Medical Equipment and Prosthetics

Durable medical equipment is covered if:

- Designed for prolonged use
- It has a specific therapeutic purpose in treating your illness or injury
- Prescribed by your physician, and
- Primarily and customarily used only for medical purposes.

Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for durable medical equipment.

Covered items include:

- Artificial limbs or eyes (including implant lenses prescribed by your provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses or braces
- Diabetic equipment for home testing and insulin administration not covered under the prescription benefit (excluding batteries)
- Initial external prosthesis and bra necessitated by breast surgery and replacement of these items when required by normal wear, a change in medical condition or additional surgery
- Oxygen and rental equipment for its administration
- Penile prosthesis when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery or an injury to the genitalia or spinal cord, and other accepted treatment has been unsuccessful; up to a maximum of 2 per lifetime
- Rental or purchase (decided by Ethix) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to $100 per lifetime.

Emergency Care

Emergency care is covered. Emergency care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient's health if not treated immediately. Examples of conditions that might require emergency care include, but are not limited to:

- Bleeding that will not stop
- Chest pain
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion — especially after a head injury.

See page 23 for instructions on what to do if you need emergency or urgent care.

If your condition does not qualify as a medical emergency (see "Definitions"), but care is urgently needed, see page 21 for more on urgent care.

Family Planning

Covered family planning expenses include:

- Birth control pills and devices requiring a prescription (birth control drugs are covered under the prescription drug benefit)
- Services to insert intrauterine birth control devices (IUDs)
- Tubal ligation
- Vasectomy
- Voluntary termination of pregnancy.

The plans do not cover:

- Sexual dysfunction treatment or related diagnostic testing
- Procedures to reverse voluntary sterilization.

Growth Hormones

Growth hormones are covered for certain medical conditions and must be preauthorized if you receive network or non-network care.

Hearing Aids

Hearing aids including fitting, rental and repair are covered up to $500 per 3-year period.

Home Health Care

Home health care services are covered if:
- Care takes the place of a hospital stay
- Part of a home health care plan, and
- Provided and billed by a licensed Washington state home health care agency.

Home health care is payable up to 130 visits per year. Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for home health care.

Covered services include:
- Nursing care
- Physical therapy
- Occupational therapy
- Respiratory therapy
- Restorative therapy
- Speech therapy (restorative only).

Services and prescription drugs provided and billed by a home infusion therapy company are also covered if the company is licensed by the state as a home health care agency.

The following services are not covered:
- Custodial care, except by home health aides as ordered in the approved plan of treatment
- Housecleaning
- Services or supplies not included in the written plan of treatment
- Services provided by a person who resides in your home or is a family member
- Travel costs or transportation services.

Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a physician; nurse; medical social worker; or physical, speech, occupational or respiratory therapist.

Hospice care services are covered if:
- Care takes the place of a hospital stay
- Part of a hospice care treatment plan, and
- Provided and billed by an organization licensed as a hospice by Washington state.

Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for hospice care.

Covered services include:
- Drugs and medications
- Emotional support services
- Family bereavement services
- Home health services
- Homemaker services
- Inpatient hospice care
- Physician's services
- Respite care for family members who care for the patient.

An extension of these benefits may be granted by a written request from your physician to Ethix.

The following services are not covered:
- Any services provided by members of the patient's family
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Funeral arrangements
- Homemaker, caretaker or other services not solely related to the patient, such as:
  - House cleaning or upkeep
  - Sitter or companion services for either the plan participant who is ill or for other family members
  - Transportation
- More than 120 hours of respite care in any 3-month period of hospice care
- Pastoral counseling.

Hospital Care

Inpatient: Covered inpatient hospital care includes:
- Hospital services, such as operating rooms, recovery rooms, isolation rooms, cast rooms; anesthesia and related supplies administered by hospital staff; drugs; splints, casts and dressings; blood, blood plasma and blood derivatives; artificial kidney treatment; oxygen and its administration; x-ray, radium and radioactive isotope therapy; x-ray and lab exams, electrocardiograms, physiotherapy and hydrotherapy
- Intensive care or coronary care units
- Newborn nursery care after covered childbirth, including circumcision
- Semiprivate room, patient meals, general nursing care (private room charges are covered only up to the hospital's semiprivate rate).

Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for inpatient care other than that necessary for up to 48 hours following a vaginal childbirth, 96 hours following a cesarean section.

Convalescent, custodial or domiciliary care is not covered.

Outpatient: Covered outpatient care includes:
- Diagnostic and therapeutic nuclear medicine in a hospital setting
- Hospital outpatient chemotherapy only for the treatment of malignancies
- Outpatient surgery
- Surgery in an ambulatory surgery center in place of inpatient hospital care.

Infertility

Covered infertility expenses include:
- Embryo transfer
- Intrauterine and intravaginal artificial insemination
- In vitro fertilization.

Infertility benefits are payable up to $25,000 for your lifetime.

The plans do not cover:
- Assisted reproductive technology (ART) methods not listed above
- Donor expenses
- Donor sperm and banking services
- Drugs to treat infertility
- Procedures to reverse voluntary sterilization
- Services for dependent children
- Sexual dysfunction.

Injury to Teeth

The services of a licensed dentist are covered for repair of accidental injury to sound, natural teeth. Injuries caused by biting or chewing are not covered. Treatment must begin within 30 days of the accident and all services must be provided within 12 months of the date of injury.

Inpatient Care Alternatives

Your physician may develop a written treatment plan for care in an equally or more cost-effective setting than a hospital or skilled nursing facility. If the alternative setting plan is approved by this plan, all hospital or skilled nursing facility (depending on what kind of care the alternative is intended to replace) benefit terms, maximums and limitations apply to the inpatient care alternatives.

Lab, X-ray and Other Diagnostic Testing

Covered services include:
- Lab or x-ray services, such as ultrasound, nuclear medicine, allergy testing
- Screening and diagnostic procedures during pregnancy as well as related genetic counseling (when medically necessary for prenatal diagnosis of congenital disorders)
- Services to diagnose or treat medical conditions of the eye by a physician or licensed optometrist; eyewear and routine vision exams and tests for vision sharpness are not covered under this benefit (see your Vision Plan booklet for details).

See “Preventive Care” on page 18 for more information on routine tests such as hearing tests and mammograms.

Maternity Care

Maternity care is covered if provided by a:
- Physician (a registered nurse whose specialty is midwifery is considered a physician for this purpose), or
- Provider licensed as a midwife by Washington state.

Covered maternity care includes:

- Complications of pregnancy or delivery
- Hospitalization and delivery, including home births and licensed birthing centers for low-risk pregnancies (see "Hospital Care" on page 13 for more information)
- Postpartum care
- Pregnancy care
- Related genetic counseling when medically necessary for prenatal diagnosis of congenital disorders of the unborn child
- Screening and diagnostic procedures during pregnancy.

The plans do not cover:

- Home pregnancy tests
- Lamaze classes
- Maternity care for children.

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

You don't need to preauthorize the length of the stay unless it exceeds the 48 or 96 hour period.

Mental Health Care

Inpatient and outpatient mental health care is covered if provided by a licensed psychiatrist (MD), licensed psychologist (PhD), licensed master's level mental health counselor, licensed nurse practitioner (ARNP), community mental health agency licensed by the Department of Health or licensed state hospital.

Covered services include:

- Individual and group psychotherapy
- Inpatient care or day treatment care instead of hospitalization must be provided in a licensed medical facility
- Laboratory services related to the covered provider's approved treatment plan
- Marriage and family therapy
- Physical exams and intake history
- Psychological testing.

Depending upon individual medical needs, alternative benefits may be available under the Medical Case Management provision of these plans. For more information on this provision, see page 8.

Inpatient mental health care is limited to 30 days per year. Outpatient mental health care is limited to 52 visits per year. Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for inpatient mental health care.

Mental Health Care (cont'd)

You also may receive these benefits through King County's Making Life Easier Program by calling 1-888-874-7290. Staff will obtain preauthorization approval as necessary and refer you to a provider for treatment.

The plans do not cover:
- Biofeedback
- Custodial care
- Specialty programs for mental health therapy not provided by these plans
- Treatment of sexual disorders.

Neurodevelopmental Therapy

The plans cover inpatient and outpatient neurodevelopmental therapy for covered family members age 6 and younger.

Neurodevelopmental therapy services are covered only if the care is:
- Furnished by providers authorized to deliver occupational therapy, speech therapy and physical therapy
- Prescribed by the patient's physician, and
- Provided because significant deterioration in the child's condition would result without such services, or to restore and improve function of the child.

Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider you must obtain preauthorization for inpatient neurodevelopmental therapy.

Physician and Other Medical and Surgical Services

The following services are covered by these plans:
- Immunization agents or biological sera, such as allergy serum
- Medical care in the provider's office
- Nutritional counseling by a licensed nutritionist or dietitian when medically necessary for disease management
- Physician services for surgery, anesthesia, home, office, hospital and skilled nursing facility visits
- Second opinions obtained prior to a treatment (the provider giving the second opinion must be qualified, either through experience or specialist training); a second opinion may be required to confirm the medical necessity of a proposed surgery or treatment plan
- Surgery and anesthesia administration.

PKU Formula

The plans cover the medical dietary formula that treats Phenylketonuria (PKU).

Prescription Drugs

These plans offer you choices for obtaining covered prescription drugs. You may use the mail order program or network pharmacies. You may order up to a 100-day supply per prescription or refill under the mail order program, or up to a 30-day supply from a retail network pharmacy.

Covered Prescription Drugs: The following prescription drugs are covered under the plans:
- Diabetic supplies — test strips, lancets, alcohol swabs and glucose tablets
- Drugs requiring a prescription under the applicable state law

- Epipen
- Federal legend prescription drugs
- Imitrex (oral and injectable)
- Injectable insulin and insulin syringes
- Norplant
- Ostomy supplies.

How to Use the Mail Order Pharmacy: The first time you use the mail order pharmacy, fill out the patient information questionnaire on your prescription drug order form. *This questionnaire only needs to be completed once*. The information is maintained by the pharmacy and will assist the pharmacist in cross-checking future medicines for drug allergies.

Each time you order, send the prescription drug order form with your payment directly to the mail order pharmacy's address on the form. You must include your physician's written prescription with your order form and payment. The pharmacy's toll-free number is shown on the prescription drug order form.

All prescriptions are processed promptly and are usually returned to you within 14 days. If you don't receive your medicine within 14 days or have questions about your medicine, call the mail order pharmacy at the toll-free number on the order form.

How to Use the Network Pharmacies: An extensive network of pharmacies has agreed to dispense covered prescription drugs to plan participants at a discounted cost and not to bill plan participants for any amounts over the copays. You may go to any network pharmacy (a referral from your network provider is not necessary).

Here's how it works:
- Choose a network pharmacy (see your enrollment materials for a list of network pharmacies; you also may call Ethix to find a pharmacy near you)
- Show your ID card to the network pharmacist each time you want a prescription filled or refilled
- Pay the copay for each covered prescription or refill
- There are no claim forms to submit; the network pharmacy will bill the plan directly.

If you do not show your ID card, and the network pharmacy cannot reach Ethix to confirm you are covered by these plans, no benefits will be provided.

The only exception is for plan participants to whom an ID card has not yet been issued. In this case, you'll need to pay the pharmacy in full and submit the claim to Ethix. Refer to page 25 for information on filing claims.

Drugs Not Covered: The following prescription drugs and items are not covered:
- Anorexiants (except for attention deficit disorder and narcolepsy where such drugs have been preauthorized)
- Drugs intended for use in a physician's office or a setting other than a home
- Growth hormones, except when preauthorized for certain medical conditions
- Infertility medications
- Injectable prescription drugs other than insulin and Depo-Provera (except where such drugs have been preauthorized)
- Investigational or experimental drugs, including compounded medications for non-FDA approved use
- Minocin

Prescription Drugs (cont'd)

- Nonlegend drugs other than insulin
- Prescriptions an eligible person is entitled to receive without charge under any workers' compensation law, or any municipal, state or federal program
- Retin-A (over age 26)
- Rogaine
- Smoking cessation products (refer to the smoking cessation benefit described on page 20 for more information)
- Therapeutic devices or appliances, support garments and other nonmedical substances.

Preventive Care

The following preventive care is covered:

- Breast exams, pelvic exams and Pap tests every year for women
- Mammograms every year for women over 40 (or as determined by provider for high-risk patients)
- Immunizations, including annual flu shots
- Routine physicals and hearing tests.

Immunizations, routine physicals and hearing tests are payable according to the following schedule:

Birth to 1 year	Routine newborn care plus 5 well-baby office exams
1 year - 18 months	1 well-child visit
2- 5 years	3 well-child visits, with 1 visit in each of these age groups: 1 - 2, 2 - 3, 3 - 4, 4 - 5
6 - 12 years	3 well-child visits, with 1 visit in each of these age groups: 6 - 8, 8 - 10, 10 - 12
13 - 17 years	2 well-teen visits, with 1 visit between ages 13 - 15 and 1 visit between ages 15 - 17
18 - 25 years	1 well-adult visit
26 - 49 years	1 well-adult visit every 4 years
50+ years	1 well-adult visit every 2 years

The above schedule is a guideline. Benefits may be available for more frequent care depending on the situation.

Radiation Therapy, Chemotherapy and Respiratory Therapy

Inpatient and outpatient services are covered for medically necessary radiation, chemotherapy and respiratory therapy when prescribed by your physician.

Reconstructive Services

Reconstructive surgery to improve or restore bodily function is covered, subject to the plans' review and approval. The plans do not cover cosmetic surgery to improve physical appearance that is not medically necessary.

Benefits available for covered individuals who are receiving benefits for a mastectomy and elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the patient and attending physician include:

- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same annual deductible and coinsurance provisions as other medical and surgical benefits (see the "Medical Plan Summary" beginning on page 3 for details).

Rehabilitative Services

The plans provide coverage for medically necessary inpatient and outpatient rehabilitative care designed to restore and improve physical functioning lost due to a covered illness or injury. Such care is considered medically necessary only if significant improvement in the lost physical function is occurring during the period that such care is provided and only if the patient's attending physician expects such significant improvement to continue. To verify whether coverage for rehabilitative services applies or continues to apply, the county has the right to obtain written opinions from such attending physician concerning whether and to what extent such significant improvement is occurring.

Inpatient services are covered to a maximum of 60 days per calendar year and must be provided by a licensed hospital. Outpatient services are covered to a maximum of 60 visits for all therapies combined per calendar year and must be provided by a licensed medical provider.

Notwithstanding the foregoing coverage for rehabilitative services, these plans do not cover services or expenses related to schools or other non-medical facilities which primarily provide educational, vocational, custodial and/or rehabilitative support training or similar services.

Skilled Nursing Facility

Skilled nursing facility services are covered if:

- Provided and billed by a licensed Washington state skilled nursing facility, and
- The care takes the place of a hospital stay.

Let your provider know a written plan of treatment is required for these services to be covered. Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for skilled nursing facility care.

Prescription drugs are covered when provided by the skilled nursing facility and used by the patient during a period of covered skilled nursing facility care.

The following services are not covered:

- Custodial care
- Services or supplies not included in your physician's written plan of treatment
- Services provided by a person who resides in your home or is a family member
- Travel costs.

Skilled nursing facility confinement for developmental disability, mental conditions or primarily domiciliary, convalescent or custodial care is not covered.

Smoking Cessation

These plans cover:

- Acupuncture to ease nicotine withdrawal
- Hypnotherapy to ease nicotine withdrawal
- Prescription drugs to ease nicotine withdrawal
- Smoking cessation programs (non-network benefits available only).

To receive benefits for a smoking cessation program, you must complete the full course of treatment. No other benefits for smoking cessation are covered.

No benefits will be provided for:

- Books or tapes
- Inpatient services
- Over-the-counter drugs, including nicotine gum or nicotine patches
- Vitamins, minerals or other supplements.

TMJ

Diagnosis and treatment of Temporomandibular Joint Disorder and Myofascial pain are covered as a medical condition up to $2,000 per calendar year. These services must be preauthorized by the plans and in general use and acceptance by the medical/dental community to relieve symptoms, promote healing, modify behavior and stabilize the condition.

Transplants

Covered services include professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care as well as certain donor expenses. Benefits may include travel and accommodations for a recipient's family member or parent and up to $100 a day for the family member's food and lodging if the care is provided out of state. These benefits are payable only until the family member's presence is no longer necessary, as determined by the plans.

Network providers will obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for transplants. The following human transplants are covered.

You will not be eligible for organ transplant benefits until the first day of the 13th month of continuous coverage under a KingCare plan — whether or not the condition is preexisting or an emergency.

If your provider recommends a transplant (even if it's not listed in this section) call Ethix immediately to discuss your situation, determine if the transplant is covered and, if so, make the necessary arrangements for your care.

The following human transplants are covered:

- Bone marrow including peripheral stem cell rescue
- Cornea
- Heart
- Heart-lung
- Kidney
- Liver
- Lung (single or double)
- Pancreas with kidney.

If you are a *transplant recipient*, covered services include all of your services and supplies including your transportation to and from designated facilities. (Designated facilities are specific facilities identified by Ethix and authorized to perform certain transplant procedures for plan participants.) You must be accepted into the facility's transplant program and continue to follow that program's prescribed protocol.

Transplant donor expenses are covered if the recipient is a plan participant. Covered services include:

- Bone marrow testing and typing of the brothers, sisters, parents and children of the patient who needs the transplant; testing and typing of any other potential donor are not covered
- Evaluation of the donor organ or bone marrow, its removal and transport of both the surgical/harvesting team and donor organ or bone marrow (if used for a covered transplant).

Benefits to locate a donor, such as tissue typing of family members, and other donor procurement costs are covered.

These plans do not cover:

- Donor costs for a transplant not covered under these plans, or for a recipient who is not a plan participant (however, complications and unforeseen effects from a plan participant's organ or bone marrow donation will be covered as any other illness)
- Donor costs for which benefits are available under other group coverage
- Non-human or mechanical organs, unless deemed non-experimental and noninvestigational by these plans
- Organ or bone marrow search or selection costs (including registry charges), except as described are covered.

Urgent Care

These plans cover urgent care, which is treatment for conditions that are not considered a medical emergency but may need immediate medical attention. (See page 31 for a definition of medical emergency.) Examples of urgent conditions include:

- Ear infections
- High fevers
- Minor burns.

Urgent care is covered the same as other care. Generally, urgent care involves an office visit and is paid at the level shown on page 4.

See page 23 for instructions on what to do if you need urgent care.

Expenses Not Covered

In addition to any exclusions or limits on the previous pages, the plans do not cover the following:

- Benefits covered by government plans: Except as otherwise required by law, benefits that are covered — or would be covered without these plans — by:
  - Any federal, state or government program (except for facilities in Ethix's list of network providers)
  - Government facilities outside the service area
  - Medicare (see "Coordination of Benefits with Medicare" on page 28)
  - Workers compensation or state industrial

Expenses Not Covered (cont'd)

- Benefits covered by other insurance you have: Benefits payable under any automobile, medical personal injury protection, homeowner, commercial premises coverage or similar contract (reimbursement to Ethix will be made without reduction for any attorney's fees, except as specified in the contract)
- Biofeedback
- Charges that exceed UCR amounts (see page 33)
- Charges with no obligation to pay: Charges that, in the absence of these plans, would have no obligation to be paid, such as services performed by a family member
- Chronic mental health condition: Inpatient or outpatient services for treatment of chronic mental conditions including but not limited to mental retardation, mental deficiency or forms of senile deterioration such as Alzheimer's conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism
- Cosmetic surgery except:
  - For all stages of reconstruction on the nondiseased breast to make it equal in size to the reconstructed diseased breast following mastectomy
  - For congenital anomalies of a dependent child
  - For reconstructive breast surgery on the diseased breast necessary because of a mastectomy
  - When related to an injury occurring while covered under these plans
- Court-ordered services or programs not judged medically necessary by the plans
- Custodial care: This includes care solely to assist with normal daily activities (such as dressing, feeding and ambulation) or any other treatment that does not require the services of a registered nurse or licensed practical nurse
- Dental: Charges to treat the teeth, except for natural teeth injured in an accident while covered by the plans (this treatment must be within 1 year of the accident); surgery due to periodontal disease is not covered
- Dependent child maternity: Treatment, services or drugs for a dependent child's pregnancy
- Diagnostic hospitalization: Hospitalization solely for diagnostic purposes when not medically necessary
- Exams: Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports or recreational activities
- Experimental or investigative services, supplies or settings (see page 30 for a definition)
- Fertility: Reversal of voluntary sterilization, voluntary removal of birth control devices implanted under the skin (for example, Norplant), any fees relating to donor sperm, menotropins (such as Pergonal) or related drug therapy, surrogate parenting fees or in vitro fertilization
- Foot care: Routine services such as hygienic care, treatment for flat feet, removal of corns or calluses, corrective orthopedic shoes, arch supports or orthotics unless needed for diabetes or other similar conditions
- Infertility: Treatment, services or drugs related to infertility, including Viagra
- Jaw abnormalities: Treatment of malocclusions of the jaw, or any related appliances (see page 20 for information on covered TMJ expenses)
- Nonapproved drugs: Drugs and substances the FDA has not approved for general use and those with the label "Caution - limited by federal law to investigational use"
- Not medically necessary: Services and supplies not medically necessary to treat illness or injury, except for newborns and unless otherwise specified

- Obesity: Surgery or other procedures, treatment or services for obesity such as gastric intestinal bypass surgery
- Relatives as providers: Services of a provider related to you by blood, marriage, adoption or legal dependency
- Schools or other non-medical facilities that primarily provide educational, vocational, custodial and/or rehabilitative support, training or similar services
- Self-inflicted injuries: Intentionally self-inflicted injuries or those sustained:
  - By an intentional overdose of a legal prescription, over-the-counter drug, illegal drug or other chemical substance
  - From suicide or attempted suicide
  - While engaged in any activity that results in a felony conviction
  - While performing any acts of violence or physical force
- Sexual dysfunction or transsexualism: Surgery, treatment or prescriptions for sexual dysfunction or transsexualism
- Third-party requirements: Treatment or evaluations required by third parties such as those for school, employment, flight clearance, summer camp, insurance or court
- Vision: Eye tests are not covered unless due to sickness or injury; also not covered are charges for:
  - Contact lenses (except for cataract surgery)
  - Eyeglasses or their fittings
  - Orthoptics
  - Radial keratotomy or similar surgery done in treating myopia
  - Visual analysis, therapy or training.

What Happens If

If You Need Emergency Care

Emergency care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient's health if not treated immediately.

If you need emergency care, follow these steps:

- Go to the nearest hospital emergency room immediately.
- When you arrive, show your medical plan membership card.
- If possible, call Ethix at 1-800-654-7714 within 48 hours; otherwise, you may be responsible for all costs incurred before you call. If you're unable to call, have a friend, relative or hospital staff person call for you. The telephone numbers are also printed on the back of your ID card.

If you have a medical emergency as determined by the plans, you receive network-level benefits for network or non-network care.

If You Need Urgent Care

Sometimes you may need to see a physician for conditions that are not life threatening but need immediate medical attention.

- For urgent care during office hours, call your physician's office for assistance.
- After office hours, call your physician's office and contact the physician on-call. Depending on your situation, the physician may provide instructions over the phone, ask you to come into his or her office or advise you to go the nearest emergency room.

If You Need Urgent Care (cont'd)

If you see a network provider for urgent care, you receive network-level benefits; if you see a non-network provider, you receive non-network benefits.

If you are unable to contact your physician or the physician on-call, contact the Ethix Personal Health Advisor at 1-800-520-1764 — the nurse can help you access appropriate care 24 hours a day.

If You Need Care While Traveling

If you need care while traveling, contact your physician for guidance.

If you receive care from non-network providers while traveling, benefits are paid at the non-network levels described in "Medical Plan Summary" on page 3. If you need emergency or urgent care while traveling, refer to the previous sections for details.

If Your Family Member Lives Away From Home

If one or more of your family members live away from home either temporarily or permanently, benefits depend on the provider they see. A family member who lives near one of Ethix's national networks may see a network provider and receive network-level benefits. Covered family members also may see a non-network provider (and receive non-network-level benefits). The same copays and deductibles for network and non-network care apply (see page 3).

Call Ethix at 1-800-654-3250 for information about network providers outside Washington.

Filing a Claim

You'll need to submit claims for non-network services. Claim forms are available from Ethix. Call Ethix at the phone number listed in the Directory (inside the front cover of this booklet).

In general, you'll have fewer claims to submit under these plans than under most plans because network providers bill Ethix directly. If you're covered by Medicare, and Medicare is your primary coverage, you must submit the Medicare Explanation of Benefits form in addition to Ethix's claim form and itemized bill.

When submitting any claim, include the itemized bill, which *must* contain:

- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service
- Itemized charges from the provider for the services received
- If treatment is the result of an accident, the date, time, location and brief description of the accident
- Group number (shown on your ID card)
- Employee's name and Social Security number, if the patient is a family member.

For efficient payment, submit all claims within 30 days after the service is provided. The plans will not pay a bill submitted more than 12 months after the date of service. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances. When there is no indication the bill has been fully paid, payment will be made to the provider.

If you receive services from a non-network provider and the bill indicates full payment has been made, payment for covered services will be made directly to you.

Medical Claims

Send your medical claims to:

Ethix
Claims Department
PO Box 91023
Seattle WA 98111-9123
1-800-654-3250

Prescription Drug Claims

Mail prescription drug claims to the address shown under "Medical Claims." You must use a prescription drug claim form and include:

- Pharmacy receipt, which shows the cost, drug's name, patient's name and date the drug was dispensed
- National Drug Code (NDC) number for each drug (found on the prescription label); *the claim cannot be processed without this number.*

Appealing a Claim

When you become eligible for benefit payments, you must follow certain steps for filing a claim. If your claim is denied in whole or in part, you will be notified in writing of the reason for the denial. The following information explains what to do if you have a problem with your claim or want to appeal a decision.

Definitions

The following definitions are intended to help in clarifying the procedures set forth below.

An Inquiry or Issue is an oral or written request for administrative service information, a criticism or recommendation. Your first communication to Ethix about any problem is considered an inquiry or issue. It is resolved at the Member Services level whenever possible. If Ethix is unable to resolve your inquiry or issue at this level, the communication will then be considered as a complaint or grievance.

A Complaint or Grievance is an expression of dissatisfaction by or on your behalf, communicated in writing, concerning any aspect of your care or a provider's performance, any matter relating to the provision of benefits, access to health care services or quality of services.

An Appeal is a request for Ethix to change a decision. Ethix will investigate and endeavor to resolve any and all issues or inquiries, complaints or grievances received from you with regard to services rendered. You may file a complaint or grievance for any reason.

Informal Grievance

When you have a complaint about the medical care process, a benefit decision or other issues, it should be brought to the attention of a Member Services representative who will work with you to try and resolve the complaint to your satisfaction on an informal basis. Call Ethix Member Services

Informal Grievance (cont'd)

at 1-800-654-3250. If that approach is unsuccessful, you have the right to take the complaint to the next step in the grievance process.

Level 1 Grievance

If a complaint is not resolved to your satisfaction at the informal grievance level you may appeal an adverse determination by sending a letter explaining your complaint to:

Ethix
Attn: Grievance and Appeals Unit
600 University Street
Suite 1400
Seattle WA 98101

Ethix will send you a written notice acknowledging receipt of the complaint within 2 business days of receipt. Ethix will review the complaint and in most cases will notify you of its decision within 14 days of receipt of the complaint. In some cases Ethix may notify you in writing that an extension is necessary to complete the review. An extension will not delay a decision beyond 30 days of receipt of the request for appeal without your written consent. You will be notified in writing of Ethix's decision regarding your appeal, and your right to access Ethix's Level 2 grievance process.

Level 2 Grievance

You and/or your representative may request reconsideration of a Level 1 grievance decision by submitting a written request within 30 days from receipt of such a decision. Such a request should be submitted to:

Ethix
Attn: Grievance and Appeals Unit
600 University Street
Suite 1400
Seattle WA 98101

A request for reconsideration will be reviewed by persons who were not involved in the Level 1 review and decision. In most cases Ethix will notify you of its decision within 14 days of receipt of the request for reconsideration. In some cases Ethix may notify you in writing that an extension is necessary to complete the review. An extension will not delay a decision beyond 30 days of receipt of the request for reconsideration without your written consent. A level 2 decision represents the final level of review by Ethix.

If you need to discuss the process or status of a Level 1 or Level 2 grievance, you may call the Grievance and Appeals Unit at 206-701-1116.

Release of Medical Information

When you join one of the KingCare plans, you authorize the claim administrator (Ethix) to receive and release information concerning your claims when necessary. In administering the plans, Ethix may need to contact your provider or other person, organization or insurance company to obtain or release information such as medical records.

Qualified Medical Child Support Order (QMCSO)

The plans may provide medical coverage to certain children of yours if directed by certain court or administrative orders. Refer to your "Important Facts" booklet for information.

Coordination of Benefits

This section applies to you if you or an eligible family member is covered by both this plan and a plan not sponsored by the county (and you expect reimbursement from both plans). If you and your eligible family member are covered under a county-sponsored plan both as an employee and as a family member, different rules may apply. Contact Benefits and Well-Being for details.

If you or your family members have additional health care coverage, benefits from the other plan(s) may be considered before benefits are paid under these plans. Additional coverage includes another employer's group benefit plan or other group arrangement — whether insured or self-funded.

The plan that must pay benefits first is considered primary and will pay without regard to benefits payable under other plans. When another plan is primary, your county-sponsored plan will coordinate benefits so you receive maximum coverage. In no case will you receive more than 100% of the covered expense.

If you or your family members are covered under another plan, be sure to keep a copy of your itemized bill and send the bill and Explanation of Benefits to your county-sponsored plan.

If the other plan does not have a coordination of benefits provision, that plan will pay first. If it does, the following rules determine payment:

- The plan covering an individual as an employee will pay first.
- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, the other plan's provisions will apply.)
- If the parents are divorced or legally separated, these rules apply:
    - If the parent with custody (or primary residential placement) has not remarried, the plan of that parent pays before the plan of the parent without custody
    - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody
    - If the court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility will pay first.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed will pay first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination procedures. For example, if the plans paid too much under the coordination of benefits provision, the plans have the right to recover the overpayment from you or your provider.

Coordination of Benefits with Medicare

If you continue to work for the county after age 65 you may:

- Continue your medical coverage under this plan and integrate the county plan with Medicare (the county plan would be primary or pay benefits first).
- Discontinue this medical coverage and enroll in Medicare. If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months. See "Continuation of Coverage (COBRA)" in your "Important Facts" booklet for information.

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to coverage as an active employee or Medicare-eligible family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact Benefits and Well-Being.

When Coverage Ends

Refer to your "Important Facts" booklet for information about when coverage ends.

Certificate of Coverage

When your coverage under one of these plans ends, you will automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under one of these plans. You will need to do this only if the other health plan has a preexisting condition limit.

Continuation of Coverage (COBRA)

Continued coverage may be available to you and your covered family members under COBRA if coverage ends because of a qualifying event. Refer to your "Important Facts" booklet for information.

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the plan benefits described in this booklet. You must pay premiums, which may be higher than the amount you currently pay, if any, for these benefits.

You will not be able to convert to the individual policy if you are eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to Ethix within 31 days after this medical coverage terminates. Evidence of insurability will not be required. You will not receive this information unless you request it. Request an application from Ethix.

Extension of Coverage

If these plans are canceled, the plan will continue to cover any participants who are hospital inpatients on the date the plans are canceled. Coverage will end on the date of discharge or when you reach the plan maximums — whichever comes first.

Assignment of Benefits

Plan benefits are available to you and your covered family members only. Refer to your "Important Facts" booklet for information.

Third Party Claims

If you receive benefits for any condition or injury for which a third party is liable, these plans may have the right to recover the money these plans paid for benefits. Refer to your "Important Facts" booklet for information.

Recovery of Overpayments

These plans have the right to recover amounts paid by these plans that exceed the amount for which these plans are liable. Refer to your "Important Facts" booklet for information.

Payment of Medical Benefits

The medical benefits offered by these plans are funded by King County (these are "self-funded" plans). This means King County is financially responsible for claim payments and other costs of the program.

Termination and Amendment of the Plans

Refer to your "Important Facts" booklet for information on termination and amendment of the plans.

Definitions

To help you better understand your medical benefits, here's a list of important definitions.

Accident. A sudden and unforeseen event that occurs at a specific time and place and results in bodily injury to the plan participant. It is independent of illness other than infection of a cut or wound received in an accident.

Annual Deductible. The amount plan participants pay each plan year before the plans pay benefits. The annual deductible does not apply to the out-of-pocket maximum.

Annual Out-of-Pocket Maximum. The most a plan participant or family pays toward coinsurance each plan year.

Brand-Name Drugs. Trademark drugs patented for a limited period by a single pharmaceutical company.

Chemical Dependency. A psychological and/or physical dependence on alcohol or a state-controlled substance. The pattern of use must be so frequent or intense that the user loses self-control over the amount and circumstances of use, develops symptoms of tolerance and, if use is reduced or discontinued, shows symptoms of physical and/or psychological withdrawal. The result is that health is substantially impaired or endangered, or social or economic function is substantially disrupted.

Coinsurance. The amount you and your plan share toward covered expenses. For example, the KingCare Preferred Plan pays 90% coinsurance for most network care, which means a participant's coinsurance is 10%.

Copay. The fixed amount you pay at the time you receive the covered service. For covered services requiring copays, see "Medical Plan Summary" starting on page 3 .

Custodial or Convalescent Care. Care primarily to assist the patient in activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the participant to walk, get in and out of bed, bathe, dress, eat or prepare special diets or take medication that is normally self-administered.

Durable Medical Equipment. Mechanical equipment that can stand repeated use and multiple users, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is prescribed by a physician.

Ethix. The organization contracted by King County to administer plan benefits, including determining network providers and claim payments.

Experimental or Investigative Services/Supplies. Any treatment, procedure, facility, equipment, drug, drug usage, medical device or supply considered experimental or investigative when furnished. To determine whether such a service/supply is experimental or investigational, the plans consider whether the services/supplies:

- Are in general use in the Washington state medical community
- Are under continued scientific testing and research
- Show a demonstrable benefit for a particular illness or disease
- Are proven safe and effective
- Result in greater benefits for a particular illness or disease than other generally available services/supplies

- Pose a significant risk to patient health or safety, and
- Have been published in authorized peer-reviewed medical literature.

After receiving a fully documented claim or preauthorization request, the plans will notify you of their decision within 20 working days. If denying benefits, the written notice will identify (by name and job title) the individual making the decision, the basis for the decision, and your right to appeal the decision.

Fully documented means all of the following are included with your claim or preauthorization request:
- Patient's hard copy clinical history, including all relevant hospital and office chart notes as well as records of all laboratory and diagnostic procedures
- All reasonably available relevant medical literature, including peer-reviewed articles that support or relate to the claim or request
- If for a drug, the booklet describing the function, indications, and FDA (Food and Drug Administration) approval; if the drug is not FDA-approved for a specific condition, documentation showing whether the drug is Group A, B or C, with supporting data
- If the treatment or procedure is part of a research protocol, copies of the research protocol and any informed consent the patient has signed or will be asked to sign
- Copies of all documents created by the institutional review board where the treatment or procedure will be performed that relate to the treatment or procedure.

Formulary. The plans' authorized list of generic and brand-name prescription drugs approved for use by the FDA .

Generic Drugs. Medications that are not trademark drugs, but are chemically equivalent to the brand-name drug.

Hospice. A private or public agency or organization with a hospice agency license that administers or provides hospice care.

Hospital. An institution licensed by the state, and — for compensation on behalf of its patients and on an inpatient basis — primarily engaged in providing diagnostic and therapeutic facilities for surgical and/or medical diagnosis as well as treatment and care of injured or ill persons by or under the supervision of a staff of physicians. The institution also continuously provides 24-hour nursing service by or under the supervision of registered nurses, or is any other licensed institution with which the plans have an agreement to provide hospital services.

The following are not hospitals: skilled nursing facilities, nursing homes, convalescent homes, custodial homes, health resorts, hospices or places for rest, the aged or the treatment of pulmonary tuberculosis.

Inpatient Services. Care provided to a patient who is hospitalized.

Legend Prescription Drugs. Prescription drugs that have an 11-digit code assigned to them by the labeler or distributor of the product under FDA regulations.

Lifetime Maximum. The maximum benefit amount a plan participant may receive from these plans in his or her lifetime.

Medical Emergency. A medical condition that threatens loss of life or limb, or may cause serious harm to the patient's health if not treated immediately.

Definitions (cont'd)

Medically Necessary. Health care services, supplies, treatment or settings considered necessary to diagnose or treat illness or injury that meets all of these criteria:

- Consistent with your symptoms, diagnosis and treatment
- Not solely for the convenience of the participant or provider
- The least costly of the adequate and available alternatives
- For inpatients, not able to be provided safely as an outpatient without adversely affecting the patient condition or quality of care
- Generally performed or accepted by the medical profession
- The most appropriate level of service or type of supply needed for the diagnosis or treatment.

These plans reserve the right to determine whether a service, supply treatment or setting is medically necessary. The fact a physician or other provider has prescribed, ordered, recommended or approved a service, supply, treatment or setting does not, in itself, make it medically necessary.

Mental Condition. A condition classified as such by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Network Benefits. The level of benefits you receive when you see a network provider. Network benefits are generally higher than non-network benefits.

Network Provider. A person, group, organization or facility under contract with these plans to furnish covered services to plan participants.

Non-Network Benefits. The level of benefits you receive when you see a non-network provider.

Non-Network Provider. A person, group, organization or facility not under contract with these plans to furnish covered services to plan participants. A non-network provider must be licensed, registered or certified to provide covered services by the state in which he or she operates.

Outpatient Services. Care provided to a patient who is not hospitalized, but who receives treatment at a licensed medical facility.

Physician. A provider licensed by the state in which he or she practices as:

- Doctor of medicine or surgery
- Doctor of osteopathy
- Doctor of podiatry
- Registered nurse
- Chiropractor
- Dentist (DDS or DMD)
- Psychologist (if licensed by the state to practice psychology and in private practice).

The plans also cover providers licensed as a physician's or osteopath's assistant, certified as a nursing assistant, or licensed as a practical nurse or registered nurse's assistant, when that provider works with or is supervised by one of the above physicians.

Preauthorization. The plans' approval for medical services or supplies given *before* the patient receives them.

Prescription Drug. Any medical substance that — under the Federal Food, Drug and Cosmetic Act (as amended) — must be labeled with Caution: federal law prohibits dispensing without a prescription.

Prescription drugs that meet the other coverage requirements of these plans will not be excluded for uses other than that stated in the drug's FDA label if the drug is recognized as effective for that use by any of the following:

- Medicare
- The American Hospital Formulary Service - Drug Information, The American Medical Association Drug Evaluation, US Pharmacopoeia - Drug Information or any other authoritative standard reference identified by Medicare or the Washington state Insurance Commissioner
- The majority of relevant peer-reviewed medical literature.

Prosthesis. An artificial substitute to replace a missing natural body part.

Provider. A person, group, organization or facility licensed to provide medical services, equipment, supplies or drugs. This includes but is not limited to naturopaths, acupuncturists, massage therapists and hypnotherapists. The provider must be practicing within the scope of his or her license.

Referral. An approved, prior authorization by your network provider (generally not required by these plans). If your physician refers you to a non-network provider, you receive non-network benefits.

Respite Care. Time off or a break for someone who is the main caregiver for an aged, ill or disabled adult or child.

Service Area . The geographic area in Washington state where these plans have arranged for covered services through agreements with various providers.

Skilled Nursing Facility. A facility that provides room and board as well as skilled nursing care 24 hours a day and is accredited as an extended care facility or is Medicare-certified as a skilled nursing facility. It is not a hotel, motel, or place for rest or domiciliary care for the aged.

Temporomandibular Joint (TMJ) Disorders. The temporomandibular joint connects the mandible, or jawbone, to the temporal bone of the skull. TMJ disorders include those with any of the following characteristics:

- Pain in the musculature associated with the TMJ
- Internal derangements of the TMJ
- Arthritic problems with the TMJ
- Abnormal range of motion or limited range of motion of the TMJ.

Urgent Care. Medical services that do not constitute a medical emergency but need immediate medical attention.

Usual, Customary and Reasonable Charge (UCR). The plans pay benefits for covered expenses up to the UCR amounts. These UCR amounts are the rates typically charged for comparable medical services provided by health care professionals in a given region with similar training and experience.

Participant Bill of Rights

Your medical coverage under these plans is administered by Ethix, a health plan administrator. Please take the time to read this booklet so you can get to know the benefits the plans offer.

As a KingCare plan participant, you have certain rights — refer to your "Important Facts" booklet for more information.

If you have questions about your benefits call or write Ethix at:

600 University Street
Suite 1400
Seattle WA 98101
1-800-654-3250